

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

C#1211034 SL#30872

96-163-037401
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 4 1963

1003

VS 300
Rev. 4/59

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2 220

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

83

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 160 DAYS	c. CITY OR TOWN ST. LOUIS, MO. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 2118 MULLANPHY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle S. Last BURGOON		4. DATE OF DEATH Month SEPTEMBER Day 27 Year 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/10/93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY ST. LOUIS, MO.	9. AGE (last birthday) 69 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR Months Days Hours Min.
11a. FATHER'S NAME JAMES A. BURGOON		11b. MOTHER'S MAIDEN NAME ROSE McDERMIT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) YES WW I		17. INFORMANT FLORA BURGOON SEE 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC EPIDERMOID CARCINOMA OF NECK EPIDERMOID CARCINOMA OF RITH PYRIFORM SINCE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 147x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4/11/63 to 9/27/63 and last saw him alive on 9/27/63 Death occurred at 5:15 A m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hans D. Sommer (Degree or title) M. D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 9/27/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/30/63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem. St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. SEP 27 1963 26. REGISTRAR'S SIGNATURE Paul Smith, M.D.	

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer _____

Signed

Licensed Embalmer No. 78410

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.